ABORTION ACKNOWLEDGEMENT AND CONSENT RECORD

Michigan Department of Community Health

| "] | | , hereby authorize |
|--|--|---|
| Dr | | ("the physician") |
| and any assistant designated by the pherocedure(s): | hysician to perform upon me the following op | eration(s) or |
| (Name of operation(s) or procedure(s | 5) | |
| | weeks pregnant. I consent to an abor that I have the right to withdraw my consent tance of that procedure. | |
| I acknowledge I have received the follo | owing: | |
| A. A copy of a medically accurate depiction of a fetus at the probable gestational age of the fetus I am carrying, preceded by an explanation that I have the option to review or not review the depiction. | | |
| · · · · · · · · · · · · · · · · · · · | dure that will be used to perform the abortion or review or not review the description. | , preceded by an |
| C. Information pertaining to potential r and with live birth. | isks and complications that have been asso | ciated with abortion |
| D. Information about what to do and w abortion. | hom to contact in the event that complication | ns arise from the |
| E. Information pertaining to available p | pregnancy related services. | |
| F. A prenatal care and parenting infor | mation pamphlet. | |
| I have been given an opportunity to ask questions about the operation(s) or procedure(s), and freely and voluntarily sign this form." | | |
| | | ☐ AM : ☐ PM |
| Signature of Patient | Date Signed | Time Signed |
| AUTHORITY: PA 133 of 1993 COMPLETION: IS REQUIRED. If not completed, the procedure MAY NOT be performed. | The Department of Community Health will not of individual or group because of race, sex, religion, ag status, political beliefs or disability. If you need he hearing, etc., under the Americans with Disabilities make your needs known to the County Health Depart | ge, national origin, marital elp with reading, writing, s Act, you are invited to |